Benchmark Benefits Flexibility under the DRA
Arizona Fact Sheet
DRAFT

Background

- In January 2009, Governor Brewer called a Special Session of the Legislature to address Arizona's mounting budget deficit. The Legislature responded in part by passing Ariz. Rev. Stat. § 36-2907.02, which directs AHCCCS to establish a mandatory "benchmark benefit package" for certain AHCCCS eligible persons, in lieu of the traditional AHCCCS benefit package.
- In recognition of Medicaid's increasing role in covering nontraditional populations, section 6044 of the federal Deficit Reduction Act (DRA) of 2005[1] gave states substantial flexibility in developing alternative benefit packages. This has enabled states to adapt their Medicaid benefits to the specific needs of individual populations, rather than the one-size-fits-all approach.
- Traditionally, Medicaid covered only elderly and disabled individuals and very low income families with children; however, in Arizona, pursuant to Arizona Proposition 204 passed by voters in 2000, AHCCCS now covers all individuals with income below 100%.

Benchmark Benefit Packages under the DRA

- Under federal law, Arizona can elect to provide benefits equal to coverage under one or more of the following benchmarks:
    1. The standard Blue Cross/Blue Shield preferred provider option under the Federal Employee Health Benefit Plan,
    2. A health benefits plan offered to state employees,
    3. The plan offered by the commercial health maintenance organization with the largest non-Medicaid enrollment in the state, or
    4. Any other plan approved by the Secretary of the Department of Health & Human Services that provides appropriate coverage to meet the needs of the covered population.
- In developing the benchmark benefit, AHCCCS will complete a benefit-by-benefit comparison of the standard AHCCCS benefit package with the state employee benefit plan, examine current utilization by the eligible populations, and consider the unique needs of urban and rural individuals.

Eligible Populations

- Ariz. Rev. Stat. § 36-2907.02 mandates enrollment of the following AHCCCS members into the benchmark plan:
    - The Proposition 204 expansion population, which is generally childless adults, and
    - Adults over age 18 receiving Transitional Medical Assistance, which includes families whose earned income has increased above the AHCCCS income limit but remains below 185% FPL. AHCCCS eligibility for TMA ends after two six-month periods.
- Children under age 19 will continue to receive the full benefit available under the Early Periodic Screening Diagnosis and Treatment program.

Process Description

- In developing an appropriate benchmark plan, AHCCCS will conduct stakeholder meetings to solicit feedback.
- AHCCCS must submit the final proposal to the U.S. Department of Health & Human Services Centers for Medicare and Medicaid Services for approval.
- AHCCCS will amend contracts with the Health Plans and develop a new capitation rate.
- Affected members will be notified in advance of any changes to their benefits.

[1] Public Law 109-171; codified at 42 U.S.C. § 1396u-7